

## Tips for problematic complications and comorbidities, A-Z

Many CDI specialists struggle with the CC and MCC lists due to their length, complexity, and specific documentation requirements. **William Haik, MD, FCCP**, director of DRG Review, Inc., in Fort Walton Beach, FL, spoke during the July 23 ACDIS audio conference “The CC and MCC MS-DRG Lists: A Clinical Review,” and offers the following tips for improving CC recognition in the medical record to ensure appropriate capture. (Look for the January 2010 **CDI Journal** for a discussion of the complete A-Z MCC list.)

### CCs

**Acute blood loss anemia (285.I):** Beginning in October 2008, CMS removed chronic and unspecified blood loss anemia from the CC list. For example, physicians now must document the phrase “acute blood loss anemia” instead of “blood loss anemia” when describing a patient with a GI bleed.

However, Haik notes that the word “acute” is a nonessential modifier for patients with postoperative blood loss anemia. (If you look up anemia, postoperative, due to acute blood loss in the alphabetic index of the *ICD-9-CM Manual*, you will find parentheses around the term acute, which means that the physician does not have to document “acute” for a coder to report 285.I.)

“Some of the encoders lead you to using the word ‘acute,’ but it’s not necessary to query the physician as long as the physician documents ‘postoperative blood loss anemia,’ ” says Haik.

**Angina, unstable (411.I):** Despite some misconceptions to the contrary, a coder may report unstable angina if a physician documents any of the following diagnoses (i.e., a query is not required):

- » Progressive angina
- » Accelerated angina
- » Initial (new onset) angina

Since angina unspecified is not a CC, some CDI specialists query physicians using terms such as “unstable” or “pre-infarction” angina. However, physicians may balk at these

queries and state that the patient does not qualify for these more severe types of angina.

Haik recommends a different line of questioning: “A softer term, such as progressive, accelerated, or new onset [initial] angina may be more appropriate, and all group under 411.I,” he says.

CDI specialists should suspect and, therefore, query for progressive/accelerated angina in patients with a known history of chronic angina whose chronic angina becomes accelerated (i.e., it occurs from less activity than is typical, Haik says). In contrast, unstable angina requires aggressive physician intervention, such as treatments of IV nitroglycerine/morphine.

When a physician documents acute coronary syndrome (ACS), he or she may not mean that the patient has angina, even though ACS, according to coding guidelines, groups to 411.I.

“ACS is a spectrum of disease relating to ischemic heart disease—it could be a patient with unstable angina, or it could be a patient with an acute myocardial infarction,” notes Haik.

If a patient is admitted with acute chest pain and has elevated biomarkers such as elevated CPK or troponin levels, query the physician to further specify the ACS as a subendocardial or transmural myocardial infarction.

**Asthma (493.xx) with acute exacerbation or status:** Look for acute exacerbation of asthma in patients that have pneumonia, are wheezing, and for whom the physician treats the asthma by ordering an administration of drugs such as Solu-Medrol or Prednisone. “Those drugs are not used for pneumonia; they are used to reduce inflammation in a patient who has a reactive airway disease such as asthma,” Haik says. If this clinical picture is present, query the physician for acute exacerbation of asthma.

**Atelectasis (518.0):** If a radiologist provides documentation of an isolated radiographic abnormality, and the attending physician does not address it (e.g., through treatment or further evaluation), do not query the physician for this condition. “These and isolated laboratory abnormalities are being targeted by [recovery audit contractors] for inappropriate reporting of

additional diagnoses,” Haik says.

**Bacteremia (790.7):** If a physician documents positive blood culture, it is a synonymous term for bacteremia within ICD-9-CM. Therefore, a CDI specialist does not need to query the physician for a coder to report bacteremia.

**Body mass index (BMI) less than 19 or greater than 40 (V85.x):** A coder may report a BMI code based solely on the nutritionist’s documentation; however, a physician must document an associated condition (such as obesity in a patient with a BMI greater than 40).

**Cachexia (799.4):** If a physician documents the term “cachexic” in a patient’s history and physical exam, a coder may report 799.4, provided that it is treated (such as with the dietary supplement Ensure).

**Cardiomyopathy (excluding ischemic) (425.x):** Cardiomyopathy does not act as a CC when the physician documents unspecified congestive heart failure as the patient’s principal diagnosis. In this instance, a CDI specialist should query the physician in an attempt to specify the patient’s type of heart failure (e.g., acute or chronic, diastolic or systolic).

**Colitis:** Infectious colitis is a CC, but viral or unspecified colitis is not. Physicians often administer antibiotics such as Levaquin or Cipro to treat a colitis patient’s diarrhea, Haik says. In these instances, the CDI specialist should query the physician as to whether he or she is treating a bacterial infection—even if the physician cannot specify the type of bacteria. If the physician answers in the affirmative, a coder may report bacterial colitis (a CC).

**Colon, redundant (751.5):** This is an unusual additional diagnosis and resides in Chapter 14 of the *ICD-9-CM Manual* (congenital anomalies). Review the diagnostic impression of the colonoscopy report for evidence of redundant colon in patients admitted for gastrointestinal conditions.

**Chronic obstructive pulmonary disease (COPD), acute exacerbation (491.21):** This may serve as a coequal principal diagnosis in a patient with pneumonia. When acute exacerbation of COPD is sequenced as the principal diagnosis, the case groups to MS-DRG I90 with a relative weight (RW) of 1.3030. However, if a coder sequences pneumonia first, the final MS-DRG is I94 with a RW of 1.0056. But remember that you must follow the definition of principal diagnosis (the condition that, after study, was found to be

chiefly responsible for that patient’s episode of care) when sequencing these two conditions.

**Drop in hematocrit (790.01):** If a physician does not provide documentation of acute blood loss anemia in a clinically appropriate circumstance, a CDI specialist may query the physician for a drop in the hematocrit. However, note that anemia is an excluded term for 790.01, which means that if the physician documents it in the record, a coder may not report 790.01. “At that point, you would have to ask the physician to specify acute blood loss anemia if it is clinically applicable,” Haik says.

**Drug-induced delirium (292.81):** Physicians often document confusion or “sundowners” secondary to postoperative pain medications in the medical record. If this occurs, query the physician to determine whether the condition can be further specified as drug-induced delirium.

**Esophagitis, acute (530.12):** Note that many physicians often document the term “esophagitis,” which is not a CC. Acute esophagitis is a CC, so query for it in clinically appropriate circumstances (e.g., the patient is receiving treatment for the esophagitis).

**Hemiplegia/hemiparesis:** Physicians frequently document left- or right-sided weakness, particularly in patients with a previous or current cerebrovascular accident (CVA). This presents an opportunity to query the physician if the left- or right-sided weakness can be further specified as a late effect of the CVA (438.2) or as hemiplegia/hemiparesis (342.xx).

**Heart failure, chronic, systolic, and/or diastolic (428.x2):** Systolic heart failure is the inability of the ventricle to contract normally and forcefully, which is normally determined by a review of the patient’s echocardiogram. The echocardiogram may show left ventricular wall dysfunction (i.e., dyssynergy) or akinesis (i.e., when no part of the wall contracts). A second indicator of systolic heart failure is the patient’s ejection fraction (EF), which is the percentage of blood ejected from the left ventricle during systole. A typical patient’s EF is approximately 60%–70%. If the medical record indicates an EF of less than 40%, the CDI specialist should query for systolic heart failure, Haik says.

Common causes for chronic systolic heart failure are ischemic heart disease and idiopathic cardiomyopathy.

Patients in diastolic heart failure may have a normal

*continued on p. 8*

## Tips

*continued from p. 7*

EF because their ventricle contracts normally. However, their ventricle does not fill adequately with blood. This is because the ventricle may be too stiff to expand and accommodate its normal blood volume or may be due to increased muscle wall thickness, which results in reduced ventricular cavity size.

Therefore, patients with diastolic heart failure have a significant reduction of blood in their ventricle and a subsequent reduced cardiac output despite having a normal EF.

Common causes of diastolic heart failure are hypertension (especially in females) and hypertrophic cardiomyopathy.

Note that in many patients with chronic heart failure, abnormalities of both ventricular contraction and relaxation coexist; therefore, chronic systolic and diastolic heart failure may occur simultaneously.

**Malnutrition (263.9):** Malnutrition is one of those rare examples in MS-DRGs “where the less you specify it, the more likely it is to be a CC,” Haik says. That’s because malnutrition, unspecified is a CC, whereas moderate or mild malnutrition are not.

Haik says some clinical criteria to consider for malnutrition include the following:

- » Ideal body weight > 70 < 85
- » Pre-albumin > 5 < 15
- » Albumin > 1.5 < 3.5

**Neuropathy, autonomic, peripheral (337.1):** This condition may exist in patients with diabetes or amyloidosis.

**Pathological fracture (733.1x):** CDI specialists need to phrase their physician queries carefully regarding pathological fractures, Haik says. For example, many physicians will not respond to queries in which a CDI specialist asks whether a patient with osteoporosis has a pathological fracture.

“When we as physicians hear the term ‘pathological,’ we tend to think ‘cancer with metastasis,’ but ICD-9-CM defines pathological fracture as occurring with less than the expected amount of trauma,” he says.

Therefore, couch your query by asking the physician whether a patient’s fracture was nontraumatic, osteoporotic, or spontaneous. These are synonymous terms with patho-

logical and do not require a further query.

**Renal failure, chronic, Stages IV and V (585.x):** Physicians often document the nonspecific term “chronic renal insufficiency” or chronic renal failure without providing the stage. In these situations, review the patient’s GFR, located in the basic metabolic profile. Haik suggests querying for Stages IV and V based on the following criteria:

- » Stage IV: GFR < 29
- » Stage V: GFR < 15 (and the patient is not on dialysis)

**Respiratory failure, chronic (518.83):** Query for this diagnosis if a stable patient with COPD or interstitial lung disease is on chronic home oxygen therapy, or if the medical record contains evidence of oxygen dependence.

**Respiratory insufficiency/distress, acute (518.82):** Do not report this as an additional diagnosis if the physician documents acute exacerbation of COPD, since acute respiratory insufficiency/distress is considered integral. However, if a patient is admitted with pneumonia, acute respiratory insufficiency/distress is a qualifier for how sick the patient is. Query for the presence of this diagnosis based on the following criteria: PO<sub>2</sub> > 60, < 70 with symptoms and treatment.

**Rhabdomyolysis (728.88):** Physicians tend to abbreviate this diagnosis using an up arrow CPK. This presents an opportunity to query the physician for rhabdomyolysis.

**Schizophrenia, most types, except unspecified (295.xx):** Physicians frequently fail to document the type of schizophrenia. Ask the physician to document whether the schizophrenia is chronic, since chronic undifferentiated schizophrenia (295.6) is a CC. An appropriate instance for query is the presence of documentation indicating that the patient is on long-term psychotropic drugs.

**Thrush (112.0):** Physicians often document “sore mouth” instead of this diagnosis, Haik says. CDI specialists should look for documentation of drugs used to treat

### Questions? Comments? Ideas?

Contact Associate Director Melissa Varnavas

Telephone: 781/639-1872, Ext. 3711

E-mail: [mvarnavas@hcpro.com](mailto:mvarnavas@hcpro.com)

thrush, which include Mycostatin and Diflucan, to form an appropriate query.

**Urinary tract infection (UTI) (599.0):** When a UTI is documented in the medical record, it may be reported even if it's only treated with oral antibiotics. However, in those circumstances when the physician only documents "pyuria,"

a CDI specialist must query the physician for further specification of a UTI prior to reporting 599.0 as an additional diagnosis. 🌸

*Editor's note: In the next issue of CDI Journal, we'll explore the MCC list.*

## IPPS Final Rule: CMS delays documentation reduction

Hospitals may be relieved that CMS delayed a 1.9% payment reduction and be pleased with a 2.1% increase, but changes in MS-DRG weights may still have a negative effect on reimbursement for fiscal year (FY) 2010.

In its FY 2010 inpatient prospective payment system (IPPS) final rule, CMS stated it would postpone a documentation and coding adjustment it proposed earlier this year. This adjustment would have resulted in CMS paying hospitals \$1 billion less in 2010, according to the American Hospital Association. In the final rule, CMS decided not to make the adjustment without having a full year of data from FY 2009.

"I think that means that hospitals can breathe a sigh of relief," says DeAnne W. Bloomquist, RHIT, CCS, president and chief consultant at Mid-Continent Coding, Inc., in Overland Park, KS.

CMS stated in a press release that it will consider phasing in future adjustments over an extended period beginning in FY 2011, based on a complete analysis of FY 2008 and 2009 data.

### MS-DRG weights affect finances

Decreases in the relative weights of some common MS-DRGs may still cause a significant payment reduction for some hospitals, Bloomquist says. For example, the frequently used MS-DRG 292, heart failure and shock with CC, had a relative weight of 1.0069 in FY 2009. In Table 5 of the 2010 final rule, CMS lists a relative weight of 0.9740. Another common MS-DRG, 194, simple pneumonia and pleurisy with CC, has a

relative weight of 1.0056 in FY 2009, whereas the 2010 table lists a relative weight of 0.9976. On the other hand, the relative weight for common MS-DRG 470, major joint replacement or reattachment of lower extremity without MCC, increased from 2.0077 to 2.0613.

Whether providers will see a payment increase or reduction depends on the case mix at their facilities, says Bloomquist.

"Everybody needs to take a look at the most common procedures and conditions at their facility and figure out where they will stand financially," Bloomquist says. "Many of the most commonly reported MS-DRGs appear to have decreases in their relative weights this year."

### Hospital-acquired conditions

CMS is not adding or removing any hospital-acquired conditions (HAC) in 2010. However, it is implementing ICD-9-CM coding changes for two diagnoses in the fall and trauma category:

- » Torus fracture of ulna (813.46)
- » Torus fracture of radius and ulna (813.47)

CMS is still interested in refining the HAC list. The final rule stated that commenters "expressed strong support for a robust program evaluation before modifying the HAC list."

CMS plans on conducting a joint evaluation of the HAC program's effect with sister agencies, such as the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Office of Public Health and Science. 🌸